FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034694

Facility Name: Oakbrook Healthcare Centre

Address: 2013 Midwest Road (Number) | Oak Brook (City) | 60523 (Zip Code)

County: DuPage

Telephone Number: (630) 495-0220 **Fax #** (630) 495-9150

IDPA ID Number: #36-3601135-001

Date of Initial License for Current Owners: 09/07/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-8112

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 30-March-2001 (Date)
(Type or Print Name) Christopher Vicere
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	126	Skilled (SNF)	126	46,116	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,248	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	154	TOTALS	154	56,364	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,415	1,667	5,512	12,594	8
9	SNF/PED					9
10	ICF	24,031	15,159		39,190	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,446	16,826	5,512	51,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.87%

D. How many bed-hold days during this year were paid by Public Aid? 18 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started September 7, 1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date October 26, 1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 126 and days of care provided 5,146

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	235,684	74,594	10,776	321,054		321,054		321,054			1
2	Food Purchase		167,035		167,035	(8,165)	158,870	(519)	158,351			2
3	Housekeeping	300,600	54,200	18,762	373,562		373,562		373,562			3
4	Laundry	55,155	38,461	4,210	97,826		97,826		97,826			4
5	Heat and Other Utilities			161,872	161,872		161,872		161,872			5
6	Maintenance	47,037	58,249	70,688	175,974		175,974	1,417	177,391			6
7	Other (specify):*											7
8	**TOTAL General Services**	638,476	392,539	266,308	1,297,323	(8,165)	1,289,158	898	1,290,056			8
	B. Health Care and Programs											
9	Medical Director			15,240	15,240		15,240		15,240			9
10	Nursing and Medical Records	1,659,337	164,091	692,530	2,515,958		2,515,958		2,515,958			10
10a	Therapy			82,063	82,063		82,063		82,063			10a
11	Activities	98,612	6,860	2,016	107,488		107,488		107,488			11
12	Social Services	84,544		5,074	89,618		89,618		89,618			12
13	Nurse Aide Training			462	462		462		462			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,842,493	170,951	797,385	2,810,829		2,810,829		2,810,829			16
	C. General Administration											
17	Administrative	119,459		84,000	203,459		203,459	(53,859)	149,600			17
18	Directors Fees											18
19	Professional Services			14,149	14,149		14,149	10,338	24,487			19
20	Dues, Fees, Subscriptions & Promotions			46,715	46,715		46,715	(15,626)	31,089			20
21	Clerical & General Office Expenses	88,025	47,855	60,816	196,696		196,696	14,447	211,143			21
22	Employee Benefits & Payroll Taxes			339,043	339,043	8,165	347,208	1,764	348,972			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,204	5,204		5,204	428	5,632			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,835	32,835		32,835	35,659	68,494			26
27	Other (specify):*							3,093	3,093			27
28	**TOTAL General Administration**	207,484	47,855	582,762	838,101	8,165	846,266	(3,756)	842,510			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,688,453	611,345	1,646,455	4,946,253		4,946,253	(2,858)	4,943,395			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oakbrook Healthcare Centre #0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			82,216	82,216		82,216	202,205	284,421			30
31	Amortization of Pre-Op. & Org.							6,699	6,699			31
32	Interest			194,033	194,033		194,033	338,154	532,187			32
33	Real Estate Taxes			58,645	58,645		58,645		58,645			33
34	Rent-Facility & Grounds			1,802,657	1,802,657		1,802,657	(1,800,000)	2,657			34
35	Rent-Equipment & Vehicles			5,642	5,642		5,642		5,642			35
36	Other (specify):*											36
37	TOTAL Ownership			2,143,193	2,143,193		2,143,193	(1,252,942)	890,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		204,445	136,241	340,686		340,686		340,686			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,281	85,281		85,281		85,281			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		204,445	221,522	425,967		425,967		425,967			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,688,453	815,790	4,011,170	7,515,413		7,515,413	(1,255,800)	6,259,613			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	50,241	30		9
10	Interest and Other Investment Income	(12,995)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(519)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,571)	21		24
25	Fund Raising, Advertising and Promotional	(16,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule *Deferred Maintenance Costs	1,417	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 8,088		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,263,888)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,263,888)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,255,800)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
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51				51
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62				62
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64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(519)	0	0	0	0	0	0	0	0	0	0	(519)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(519)	0	0	0	0	0	0	0	0	0	0	(519)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(53,859)	0	0	0	0	0	0	0	0	0	(53,859)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,522	0	0	0	0	0	0	0	0	0	1,522	19
20	Fees, Subscriptions & Promotions	(16,485)	809	0	0	0	0	0	0	0	0	0	(15,676)	20
21	Clerical & General Office Expenses	(13,571)	28,018	0	0	0	0	0	0	0	0	0	14,447	21
22	Employee Benefits & Payroll Taxes	0	1,764	0	0	0	0	0	0	0	0	0	1,764	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	428	0	0	0	0	0	0	0	0	0	428	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	3,093	0	0	0	0	0	0	0	0	0	3,093	27
28	**TOTAL General Administration**	(30,056)	(18,225)	0	0	0	0	0	0	0	0	0	(48,281)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,575)	(18,225)	0	0	0	0	0	0	0	0	0	(48,800)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	50,241	110	0	0	0	0	0	0	0	0	0	50,351	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,995)	19,067	0	0	0	0	0	0	0	0	0	6,072	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	37,246	19,177	0	0	0	0	0	0	0	0	0	56,423	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,671	952	0	0	0	0	0	0	0	0	0	7,623	45

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Salary - Cynthia and Laurence	$	Lancaster, Ltd.	100.00%	$ 26,077	$ 26,077	1
2	V	27	P/R Taxes-Cynthia and Laurence		Lancaster, Ltd.	100.00%	728	728	2
3	V	17	Management Fee Income	84,000	Lancaster, Ltd.	100.00%		(84,000)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	1,522	1,522	4
5	V	21	Office Expenses		Lancaster, Ltd.	100.00%	1,750	1,750	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	1,764	1,764	6
7	V	24	Education and Seminars		Lancaster, Ltd.	100.00%	428	428	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	4,064	4,064	8
9	V	32	Interest		Lancaster, Ltd.	100.00%	19,067	19,067	9
10	V	30	Depreciation		Lancaster, Ltd.	100.00%	110	110	10
11	V	21	Salaries - Clerical		Lancaster, Ltd.	100.00%	26,268	26,268	11
12	V	27	P/R Taxes - Clerical		Lancaster, Ltd.	100.00%	2,365	2,365	12
13	V	20	Advertising		Lancaster, Ltd.	100.00%	809	809	13
14	Total			$ 84,000			$ 84,952	$ * 952	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	33.34%	See Attached	2	3.00%	Lancaster	$ 11,077	17-7	1
2	Laurence Zung	Officer	Administrative	33.33%	See Attached	2	4.17%	Lancaster	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,077		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 3520 W. Thorndale Ave.
City / State / Zip Code: Chicago, IL . 60659
Phone Number: (773) 539-8181
Fax Number: (773) 539-8133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 360,000	$ 360,000	2	$ 11,077	1
2	27	Cynthia Chow	Hours Worked	65	7	10,054	0	2	309	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	2	15,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,054	0	2	419	4
5										5
6										6
7	19	Professional Services	Management Fees	1,455,000	7	26,361	0	84,000	1,522	7
8	21	Office Expenses	Management Fees	1,455,000	7	30,313	0	84,000	1,750	8
9	22	Employee Benefits	Management Fees	1,455,000	7	30,548	0	84,000	1,764	9
10	24	Education and Seminars	Management Fees	1,455,000	7	7,408	0	84,000	428	10
11	17	Administrative Consultant	Management Fees	1,455,000	7	70,392	0	84,000	4,064	11
12	32	Interest	Management Fees	1,455,000	7	330,276	0	84,000	19,067	12
13	30	Depreciation	Management Fees	1,455,000	7	1,898	0	84,000	110	13
14	21	Salaries - Clerical	Management Fees	1,455,000	7	454,998	454,998	84,000	26,268	14
15	27	P/R Taxes Clerical	Management Fees	1,455,000	7	40,971	0	84,000	2,365	15
16	20	Advertising	Management Fees	1,455,000	7	14,009	0	84,000	809	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,747,282	$ 1,174,998		$ 84,952	25

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Reality Capital		X	Mortgage	$49,956.72	11/01/98	$ 8,152,700	$ 8,020,473	11/30/34	6.63%	$ 533,719	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Oak Brook Bank		X	Working Capital	Int. Only				Demand	Prime	256	6
7	Harston Investments		X	Working Capital							20,700	7
8	Oak Brook Associates	X			Int. Only					Prime	173,077	8
9	TOTAL Facility Related				$49,956.72		$ 8,152,700	$ 8,020,473			$ 727,752	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,152,700	$ 8,020,473			$ 727,752	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	57,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	57,645	2
3. Under or (over) accrual (line 2 minus line 1).	$	645	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	58,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,645	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	54,146	8
	1996	54,954	9
	1997	56,070	10
	1998	56,523	11
	1999	57,645	12

Based on 1999 actual taxes

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 234,464
2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 6,699
4. Dates Incurred: 26-Oct-98

Nature of Costs: Pre-Operating Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility		1998	$ 830,000	1
2					2
3	TOTALS			$ 830,000	3

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	154				$ 3,586,000	$ 91,949	40	$ 91,949	$	$ 233,704	4
5	144		1992	1994	1,863,459	59,157	35	59,157		448,118	5
6	10		1994		25,000	641	35	641		4,719	6
7											7
8											8
	Improvement Type**										
9	Various			1988	8,828	286	20	537	251	6,646	9
10	Various			1989	92,298	3,426	20	4,476	1,050	54,846	10
11	Various			1990	24,448	595	20	937	342	11,969	11
12	Various			1991	2,212	70	15	70		814	12
13	Various			1992	1,275,149	40,483	20	49,672	9,189	494,475	13
14	Various			1993	289,021	6,465	15	9,894	3,429	104,490	14
15	Various			1994	10,459	317	15	317		2,826	15
16	Various			1995	52,918	473	15	923	450	10,144	16
17	Room #112 remodeling			1996	2,285	59	15	114	55	570	17
18	Nurses' call station			1996	10,545	270	15	527	257	2,284	18
19	Ceramic tiled bathroom and tub room			1996	15,362	394	20	768	374	3,392	19
20	Rehab room			1997	31,848	817	15	1,592	775	6,235	20
21	Fire doors			1997	3,013	77	15	151	74	591	21
22	Physical Therapy room			1997	6,749	173	15	337	164	1,320	22
23	12 bathrooms vented			1997	8,670	222	15	434	212	1,591	23
24	Roof improvements			1997	7,150	183	15	358	175	1,253	24
25	Excelon vinyl tiles - 1st floor			1997	15,600	400	15	780	380	2,535	25
26	Excelon vinyl tiles - 1st floor			1998	6,204	159	15	310	151	930	26
27	New roof			1998	3,850	99	15	99		235	27
28	Custom cabinets			1998	3,285	84	15	84		200	28
29	Fire alarm switch			1998	6,996	179	15	179		380	29
30	3 shower rooms rehab			1999	15,560	399	15	399		715	30
31	Hot Water Heater			1999	7,269	186	15	186		256	31
32	Parking Lot Asphalt			1999	28,900	741	15	741		1,142	32
33	Rehab resident rooms			1999	17,825	457	15	457		628	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 7,420,903	$ 208,761		$ 226,089	$ 17,328	$ 1,397,008	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 482,036	$ 19,160	$ 50,582	$ 31,422	10	$ 278,276	37
38	Current Year Purchases	14,471	2,895	2,895		10	2,895	38
39	Fully Depreciated Assets	312,208	3,364	4,855	1,491		312,208	39
40								40
41	TOTALS	$ 808,715	$ 25,419	$ 58,332	$ 32,913		$ 593,379	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 9,059,618	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 234,180	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 284,421	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 50,241	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,990,387	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		***Off-site Public Storage Space***			2,657			5
6								6
7	TOTAL				$ 2,657 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,642 Description: $277.90 / month for Toshiba Copier AND $207.38 / month for Landen Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 32

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		143	319		462
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 143	$ 319	$	$ 462
10	SUM OF line 9, col. 1 and 2	(e)	$ 462			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	20
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	9
2. From other facilities (f)	
TOTAL TRAINED	29

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 31,290	$		$ 31,290	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,240			4,240	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			40,320			40,320	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				109,615		109,615	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Inhalation Therapy Other (specify): Med.Sup./Sp. Bed Rent	39-3 39-2				60,391	94,830		60,391 94,830	13
14	TOTAL			$		$ 136,241	$ 204,445		$ 340,686	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (71,394)	$ 28,983	1
2	Cash-Patient Deposits	18,534	18,534	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,383,942	1,383,942	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,420	9,420	6
7	Other Prepaid Expenses	44,073	309,814	7
8	Accounts Receivable (owners or related parties)	584,544	588,533	8
9	Other(specify): Employee Advances	6,036	6,036	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,975,155	$ 2,345,262	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		830,000	13
14	Buildings, at Historical Cost		3,586,000	14
15	Leasehold Improvements, at Historical Cost	1,898,054	3,786,513	15
16	Equipment, at Historical Cost	668,021	788,676	16
17	Accumulated Depreciation (book methods)	(1,109,128)	(1,963,280)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		234,464	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,515)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,456,947	$ 7,247,858	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,432,102	$ 9,593,120	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,535,147	$ 2,535,147	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,524	26,524	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,629	146,629	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,038	13,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,000	58,000	32
33	Accrued Interest Payable		44,280	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,779,338	$ 2,823,618	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,020,473	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,020,473	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,779,338	$ 10,844,091	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 652,764	$ (1,250,971)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,432,102	$ 9,593,120	48

***(See instructions.)**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 396,850	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 396,850	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	255,914	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 255,914	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 652,764	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,161,590	1
2	Discounts and Allowances for all Levels	(972,107)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,189,483	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	284,063	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 284,063	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	14,908	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	113,500	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,233	19
20	Radiology and X-Ray	400	20
21	Other Medical Services	133,279	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 281,320	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,995	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,995	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commission	3,466	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,466	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,771,327	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,297,323	31
32	Health Care	2,810,829	32
33	General Administration	838,101	33
	B. Capital Expense		
34	Ownership	2,143,193	34
	C. Ancillary Expense		
35	Special Cost Centers	340,686	35
36	Provider Participation Fee	85,281	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,515,413	40
41	**Income before Income Taxes (line 30 minus line 40)****	255,914	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 255,914	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. Return not completed.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,986	2,454	$ 72,729	$ 29.64	1
2	Assistant Director of Nursing	2,010	2,283	64,628	28.31	2
3	Registered Nurses	30,635	34,192	722,489	21.13	3
4	Licensed Practical Nurses	6,834	7,366	128,304	17.42	4
5	Nurse Aides & Orderlies	64,128	69,359	643,851	9.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,026	2,280	26,933	11.81	9
10	Activity Assistants	8,093	8,754	71,679	8.19	10
11	Social Service Workers	6,425	6,857	84,544	12.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,576	28,167	235,684	8.37	15
16	Dishwashers					16
17	Maintenance Workers	3,939	4,297	47,037	10.95	17
18	Housekeepers	35,146	38,422	300,600	7.82	18
19	Laundry	7,498	7,887	55,155	6.99	19
20	Administrator	1,970	2,107	75,739	35.95	20
21	Assistant Administrator	2,050	2,187	43,720	19.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,918	7,025	88,025	12.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,831	2,091	27,336	13.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,065	225,728	$ 2,688,453 *	$ 11.91	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	269	$ 10,776	1-3	35
36	Medical Director	381	15,240	9-3	36
37	Medical Records Consultant	77	3,024	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	1,708	10-3	39
40	Physical Therapy Consultant	1,601	82,063	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	2,016	11-3	44
45	Social Service Consultant	133	5,074	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,610	$ 119,901		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9,033	$ 288,103	10-3	50
51	Licensed Practical Nurses	127	2,488	10-3	51
52	Nurse Aides	32,837	397,207	10-3	52
53	TOTAL (lines 50 - 52)	41,997	$ 687,798		53

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joanne Bedrosian	Aministrator	N/A	$ 75,739
Rose Rivera	Asst. Adm.	N/A	43,720
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,459

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 84,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 84,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems	Data Processing	$ 5,645
Power Software Development	Data Processing	3,454
Econocare	Purchasing Consultant	390
Winston & Strawn	Legal	140
Lasko & Kocol	Legal	865
Frost Ruttenberg & Rothblatt	Accounting	3,655
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,149

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,252
Unemployment Compensation Insurance	16,042
FICA Taxes	202,543
Employee Health Insurance	73,535
Employee Meals	8,165
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contribution	10,551
Uniforms	4,001
Employment Fees	5,119
Lancaster Allocation	1,764
TOTAL (agree to Schedule V, line 22, col.8)	$ 348,972

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,619
Health Care Worker Background Check	
(Indicate # of checks performed 362)	5,792
Promotional Advertising	15,676
Dues & Subscriptions	1,769
Licenses and Fees	14,659
Lancaster Allocation	809
Oak Brook Allocation	50
Less: Public Relations Expense	(15,676)
Non-allowable advertising	(809)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,089

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	28
Seminar Expense	5,176
Lancaster Allocation	428
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,632

**See instructions.

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting and Decorating	Oct-96	$ 3,580		$ 1,193	$ 1,193	$ 597	$	$	$	$	$	$
2	Painting and Decorating	Apr-97	5,021		837	1,674	1,674	836					
3	Painting and Decorating	Nov-97	3,491		582	1,164	1,164	581					
4													
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20	TOTALS		$ 12,092		$ 2,612	$ 4,031	$ 3,435	$ 1,417	$	$	$	$	$

Facility Name & ID Number Oakbrook Healthcare Centre **#** 0034694 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,515** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,281**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,165** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.